For me. For all.
Swiss health study

Pilot phase

STUDY VISIT

The English version of this questionnaire was only developed for the codebooks and was not available during data collection.

For me. For all.
Swiss health study

Pilot phase

Exposure assessment (EX2)

Interview during study visit

Environment and exposure

Occupational exposures

1	**What is your current employment situation, and that of your partner? Tick the appropriate boxes; leave blank if you do not currently have a partner.** *Multiple answers possible.*		
	Current employment situation	**Myself**	**Spouse / partner**
	Employed full-time (80% or more)	☐	☐
	Full-time housewife/househusband (80% or more)	☐	☐
	Employed part-time (less than 80%)	☐	☐
	Employed on an hourly or irregular basis	☐	☐
	Unemployed	☐	☐
	Never worked before	☐	☐
	In training	☐	☐
	On leave : more than 3 months (vacation, maternity leave, etc.)	☐	☐
	Not working because of illness or inability to work (incl. disability insurance)	☐	☐
	Retired	☐	☐
	Retired with secondary activity (incl. volunteer work)	☐	☐
	Volunteering	☐	☐
	Other (please specify) _____	☐	☐
	I do not wish to answer	☐	☐

2	**What is the name of your current profession and what activities do you do?** *Please be as specific as possible.*

Current occupation and main activities:

_____

_____

(e.g. pharmacist with personnel management, logistics management, commercial employee with customer service and stock management, etc.)

Since when : _____year (e.g. 2001)

Employer : _____(Name)

_____(Location, address)

☐☐☐☐☐☐ Business sector (classification according to NOGA with 6 digits, see https://www.kubb-tool.bfs.admin.ch/en)

I do not wish to answer this question ☐

3	**Could you please describe your work history (jobs lasting more than one year)?** *Please list your past jobs, from the most recent to the oldest.*					
	from (year)	until (year)	Employer	Place of work	Occupation	Sector
1						
2						
3						
4						
5						
6						
I do not wish to answer / I do not remember ☐						

4	**How would you describe your usual work schedule?** *Please refer to your main profession or, if you are no longer active, to your longest commitment.* *Only one answer per line.*

		Regularly	Irregularly	On call	Never
a	Day work	☐	☐	☐	☐
b	Night work	☐	☐	☐	☐
c	Alternative day and night work	☐	☐	☐	☐

5	**How many times per month do you work at night, i.e. at least 2 hours between 11 p.m. at night and 6 a.m. in the morning?** *Only one answer possible.*

☐ Never
☐ Yes - Number of nights per month: ☐☐

6	**In the course of your working life, have you been or are you currently exposed to the following nuisances?**

a	Smoke (excluding cigarette smoke, but e.g. from burns, welding, soldering)	☐ Yes ☐ No ☐ I don't know If yes, please specify the type of smoke and the exposure interval _____ (type of smoke) __ __ __ __ – __ __ __ __ (from – until (years))
b	Exhaust gases (e.g. from diesel or petrol engines)	☐ Yes ☐ No ☐ I don't know If yes, please specify the type of gas and the exposure interval _____ (type of gas(es)) __ __ __ __ – __ __ __ __ (from – until (years))
c	Solvent vapours (e.g. formaldehyde, acetone)	☐ Yes ☐ No ☐ I don't know If yes, please specify the type of products and the exposure interval _____ (type of products) __ __ __ __ – __ __ __ __ (from – until (years))

d	Cleaning agents	☐ Yes ☐ No ☐ I don't know If yes, please specify the type of products and the exposure interval _____ (type of products) __ __ __ __ – __ __ __ __ (from – until (years))
e	Dust (e.g. mineral dust, house dust, cement dust, plastic dust)	☐ Yes ☐ No ☐ I don't know If yes, please specify the type of dust and the exposure interval _____ (type of dust) __ __ __ __ – __ __ __ __ (from – until (years))
f	Radiation (e.g. X-rays, radioactive radiation, radar radiation)	☐ Yes ☐ No ☐ I don't know If yes, please specify the type of radiation and the exposure interval _____ (type of radiation) __ __ __ __ – __ __ __ __ (from – until (years))

7	Are you or have you ever been in regular contact with the following substances or materials in the course of your professional career?	
a	Polycarbonate (e.g. production of polycarbonate products)	☐ Yes ☐ No ☐ I don't know If yes, from when to when (in years) __ __ __ __ – __ __ __ __ (from – until)
b	Epoxy resins (e.g. building materials, flooring, metal coatings, model making, ship building, car parts)	☐ Yes ☐ No ☐ I don't know If yes, from when to when (in years) __ __ __ __ – __ __ __ __ (from – until)
c	Mercury (e.g. manufacture of dental fillings or illuminants, handling of Hg-containing thermometers, manometers).	☐ Yes ☐ No ☐ I don't know If yes, from when to when (in years) __ __ __ __ – __ __ __ __ (from – until)
d	Ski wax or other waxes (e.g. metal moulds, casting waxes)	☐ Yes ☐ No ☐ I don't know If yes, from when to when (in years) __ __ __ __ – __ __ __ __ (from – until)
e	Impregnation sprays (e.g. moisture protection of shoes, clothing)	☐ Yes ☐ No ☐ I don't know If yes, from when to when (in years) __ __ __ __ – __ __ __ __ (from – until)
f	Receipts or other thermal paper	☐ Yes ☐ No ☐ I don't know If yes, from when to when (in years) __ __ __ __ – __ __ __ __ (from – until)

8	**In the framework of your work, are you or have you been in regular contact with pesticides (herbicides, insecticides, etc.)?**

☐ Yes
☐ No

If yes :
a. When did you last come into contact with a plant protection product (preparation or application)?
(see below for further questions regarding place, activity, etc.)

_____

What was the name of the last plant protection products used?

_____

If the product name is unknown: was it in liquid, powder or granular form? Did it need mixing? Against which organism did you use it? What colour was the packaging? Was it a bottle or a carton?

_____
_____
_____

Activity details for people who answered "yes" to one of questions 6-8

Question reference number	Task description	Task location	Ventilation type	Over what period of time is or was the task regularly performed?	Frequency of task (how often do you perform this task, per day, week, month or year)	Usual duration of the task.	Level of physical activity required to perform the task (low: no breathlessness, moderate: causing slight breathlessness, intensive: causing breathlessness and sweating)	Respiratory and/or skin protection (please specify).
32b	*Example : loading plastic bags of pellets.* *Please be as precise as possible.*	*Warehouse, 100 m^2*	*Irregular ventilation via windows*	*During the last 6 months*	*5-6 times per day on 5 days of a working week*	*15 minutes*	*moderate*	*Respiratory mask and gloves.* *If known, please specify the material of the gloves.*

Leisure activities, hobbies and specific exposures

9	**Do you have a vegetable or ornament garden where you use plant protection products (pesticides, herbicides, etc) or fertilisers?**

☐ Yes
☐ No

If yes :
a. When was the last time and how did you apply a plant protection product yourself?

_____

b. What was the plant protection product's name?

_____

c. If the product name is unknown: was it in liquid, powder or granular form? Did it need mixing? Against which organism did you use it? What colour was the packaging? Was it a bottle or a carton?

_____

d. What protective measures do you take when applying a plant protection product (e.g. none, gloves, mask, goggles)?

_____

10	**Do you wax your skis/snowboard yourself?**

☐ Yes
☐ No

If yes, how often do you wax a pair of skis/snowboard in a season?

_____

Where do you wax the skis/snowboard (e.g. indoors, garage, balcony, garden)?

_____

11	**Do you use impregnation sprays (e.g. for shoes, jackets)?**

☐ Yes
☐ No

If yes, how often do you use them per year?

_____

Where do you use them? (indoor, garage, balcony, garden....)

_____

12	**How many till receipts or park tickets have you had in your hands in the last 2 days (in a private or professional context).** *One answer possible.*

☐ None
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ >7
☐ I don't know

13	**Do you have or have you had any tattoos ?** *Please specify below.*

☐ No tattoos
☐ Yes, I have or have had a tattoo(s)

Tattoo	Placement (body part)	Size (cm^2), see list	Color(s) (dominant color first)	When was it tattooed (year) ?	Location, country (place of realization)	Has it been removed? If yes when and how ?
1						
2						
3						
4						

☐ I do not wish to answer the question

Lifestyle

Nutrition

14	**What portion sizes of the following foods do you eat per meal and how many times a day?** *(see photobook to estimate portion size)*		
		Portion size 0 1 2 3	Number of servings per day (if several times a day)
A	Animal milk (also in coffee, tea, muesli, etc., no other dairy products)	☐ ☐ ☐ ☐	☐☐
B	Eggs (breakfast egg, omelette etc.)	☐ ☐ ☐ ☐	☐☐
C	Fish, seafood, fish products (e.g. also tuna on pizza)	☐ ☐ ☐ ☐	☐☐
D	Breakfast cereals (muesli, oatmeal, corn flakes, etc.)	☐ ☐ ☐ ☐	☐☐

15	**How many portions of bread, pasta, breakfast cereals and pulses have you eaten in the last 48 hours?** *(see photobook to estimate portion size)*		
		Portion size 0 1 2 3	Number of servings
A	Bread, plaited loaves and others (portion size)	☐ ☐ ☐ ☐	☐☐
B	Pasta	☐ ☐ ☐ ☐	☐☐
C	Breakfast cereals (muesli, oatmeal, corn flakes, etc.)	☐ ☐ ☐ ☐	☐☐
D	Pulses (lentils, peas, chickpeas etc.)	☐ ☐ ☐ ☐	☐☐

16	**In the last 48 hours, how many meals have you or someone in your household prepared?**

Breakfast	Lunch	Dinner
☐0 ☐1 ☐2	☐0 ☐1 ☐2	☐0 ☐1 ☐2

17	**For meals prepared by you in the last 48 hours, how many of the portions eaten came from cans/tins?** *(see photobook to estimate portion size)*

	Foods	Portion size (Portion number, cf. photobook)	Number of servings
a	_____	☐☐☐☐☐	☐☐
b	_____	☐☐☐☐☐	☐☐
c	_____	☐☐☐☐☐	☐☐
d	_____	☐☐☐☐☐	☐☐

Physical activity

Please answer the following questions taking as reference a "typical" week. If the last 7 days represent an unusual week, think of the last typical week for your answers. An estimate is better than "no answer" or "I don't know".

18	**Moderate physical activity (or moderately intense).** *One answer per subquestion (a-b).*	
a	In a typical week, how often do you engage in moderate physical activity (causing slight breathlessness) such as dancing, gardening, brisk walking, etc.?	☐ Never ☐ Less than once a week ☐ 1 day a week ☐ 2 days a week ☐ 3 days a week ☐ 4 days a week ☐ 5 days a week ☐ 6 days a week ☐ 7 days a week ☐ I don't know
b	On these days, how long are you active on average?	_ _ _ minutes per day

19	**Strenuous physical activity** *One answer per subquestion (a-b).*	
a	In a typical week, how often do you engage in strenuous physical activity during which you get out of breath or sweat?	☐ Jamais ☐ Moins d'1 fois par mois ☐ Moins d'1 fois par semaine ☐ 1 jour par semaine ☐ 2 jours par semaine ☐ 3 jours par semaine ☐ 4 jours par semaine ☐ 5 jours par semaine ☐ 6 jours par semaine ☐ 7 jours par semaine ☐ Je ne sais pas
b	How many hours a week do you exercise to the point of being out of breath or sweating?	_ _ h _ _ min per week

20	**In the past week, on how many days did you engage in physical activity that made you sweat or out of breath for at least 30 minutes (e.g. training, brisk walking, cycling, in your free time or while going from a place to another)?** *Physical activity during work or housework is not taken into account.* *One answer possible only.*
	☐ 0 (no day) ☐ 1 day ☐ 2 days ☐ 3 days ☐ 4 days ☐ 5 days ☐ 6 days ☐ 7 days

21	**On average, how much time did you spend seated in the past 7 days?**	
a	On week days (Monday to Friday)	☐☐ : ☐☐ Per day Hours(s) minutes
b	During the weekend (Saturday and Sunday)	☐☐ : ☐☐ Per day Hours(s) minutes

22	**Which means of transport do you usually use to get to work (One way journey only)? How long do you use each means of transport?** *Multiple answers possible, please fill in the corresponding time.*	
		Minutes per day
	☐ By foot	☐☐
	☐ By bike	☐☐
	☐ By e-bike	☐☐
	☐ By public transport (underground, tram, bus, train)	☐☐
	☐ By car	☐☐
	☐ By motorbike/scooter	☐☐
	☐ Other, namely _____	☐☐

Exposure to Legionella

The following questions refer to risk factors for Legionella infection.

You have indicated that you have contracted Legionnaires' disease. The following questions are designed to identify the cause. (*RedCap: Questions should only appear, if «Legionellose» is crossed in question 9.1 health matrix*)

23 **Please comment on the following statements. The statements refer to the water supply (including shower, bath) of your main residence.**

Main residence	No	Yes	I don't know
The maximum water temperature does not seem warm enough			
The hot water seems to come on slowly when you turn on the tap			
The water only seems to get cold slowly when you turn on the tap			
The cold tap water quickly warms up, if the tap has not been used for a while			
Some water pipes are barely used at all			
Some water pipes are never used			
Some water pipes are rarely used (less than once a week)			
The tap water has an unusual colour			
The tap water has an unusual smell			
Certain/all water pipes and/or fittings are corroded			
Certain/all water pipes and/or fittings are broken			
The water pressure is weak			
The water pressure is variable			
Other problem with the water supply (please specify)			

Do you have a secondary flat or house where you regularly spend time?

□ Yes
□ No

If yes, please complete the following table for the second home.

Second home	No	Yes	I don't know
The maximum water temperature does not seem warm enough			
The hot water seems to come on slowly when you turn on the tap			
The water only seems to get cold slowly when you turn on the tap			
The cold tap water quickly warms up, if the tap has not been used for a while			
Some water pipes are barely used at all			
Some water pipes are never used			
Some water pipes are rarely used (less than once a week)			
The tap water has an unusual colour			
The tap water has an unusual smell			
Certain/all water pipes and/or fittings are corroded			
Certain/all water pipes and/or fittings are broken			
The water pressure is weak			
The water pressure is variable			
Other problem with the water supply (please specify)			

24	Over the past 12 months - either continuously or seasonally - how often have you done the following activities?

Activity	At least once a week	At least once a month	Less than once a month	Never
Gardening (garden or balcony) with soil contact				
Working with compost				
Cleaning cars in car washes				
Visit to an indoor swimming pool				
Visit to an outdoor swimming pool				
Use of a private swimming pool (indoors)				
Use of a private swimming pool (outdoors)				
Spa visit (sauna, Turkish bath, etc.)				

25 Have you travelled in the last 12 months?

□ Yes
□ No

If yes, please specify the following points:

Travel dates Start date – End date	Trip destination	Accommodation type
_ _ . _ _ . _ _ _ _ _ _ . _ _ . _ _ _ _	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _	□ Holiday home □ Hotel with spa □ Hotel without spa □ Youth Hostel □ AirBnB □ Camping □ With family or acquaintances □ Other (please specify)
_ _ . _ _ . _ _ _ _ _ _ . _ _ . _ _ _ _	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _	□ Holiday home □ Hotel with spa □ Hotel without spa □ Youth Hostel □ AirBnB □ Camping □ With family or acquaintances □ Other (please specify)
_ _ . _ _ . _ _ _ _ _ _ . _ _ . _ _ _ _	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _	□ Holiday home □ Hotel with spa □ Hotel without spa □ Youth Hostel □ AirBnB □ Camping □ With family or acquaintances □ Other (please specify)
_ _ . _ _ . _ _ _ _ _ _ . _ _ . _ _ _ _	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _	□ Holiday home □ Hotel with spa □ Hotel without spa □ Youth Hostel □ AirBnB □ Camping □ With family or acquaintances □ Other (please specify)

For me. For all.
Swiss health study

Pilot phase

Participant examination form (PEF)

During study visit

Instrument: Health examination

0	**Start of examination**	
a	Nurse / FW ID	_____
b	Date and time	__-__-__ __ :__ :__ (D-M-Y H : M :S)
c	Identity check	☐ The nurse confirms that he/she has verified the participant's identity
	Ev. 2nd exam – Date and time of examination	__-__-__ __ :__ :__ (D-M-Y H : M :S)

Instrument: Consent

All data collected is treated as **strictly confidential, coded** and used exclusively for scientific purposes.
We take data protection and confidentiality very seriously.

CONSENT FORM FOR SHeS – PILOT PHASE

1	**I agree…**		
	to take part in the health examination	☐ Yes	☐ No
	to receive the results of the health examination and laboratory results conducted directly at the research study centre	☐ Yes	☐ No
	to measure my physical activity with a wearable device (accelerometer) during 8 consecutive days	☐ Yes	☐ No
	to use the smartphone food tracking app MyFoodRepo	☐ Yes	☐ No
	to donate biological samples for research purposes (blood and urine)	☐ Yes	☐ No
	to be recontacted for a potential participation in the main study if it takes place	☐ Yes	☐ No
	that my samples and data collected during the pilot phase be used for the main study, if it takes place	☐ Yes	☐ No

☐ The study nurse confirms that the participant has signed the consent form

At the end of the study visit, don't forget to scan and download the consent form into the PMT (Consent storage Instrument)

Instrument: Urine PoC

2	Now offer to provide a urine sample

The bladder must be emptied at the latest before the BIA and preferably also before the anthropometric measurements. If the participant is unable to provide a sufficient quantity of urine for analysis before the BIA, he/she is entitled to drink as much water as he/she wishes after the BIA.

Time of urine collection ___ :___ (H:M)

3	ALERE ACR Test (Kidney function)

Menstruation: If the participant is menstruating, she is not eligible for this test. Please skip it and indicate reasons in the comment section.

Test performed ☐ No ☐ Yes

Nurse who performed the test (FW ID) _____

Time of ACR test ___ :___ (H:M)

Device used:
☐ SHeS-AL01L
☐ SHeS-AL02L
☐ SHeS-AL01- Bern

RESULTS

ACR (Albumin / Creatinine) _____ mg/mmol

Albumin _____ mg/L

Creatinine _____ mmol/L

Problems with the ACR test - Comments:

Instrument: Screening Questionnaire

SCREENING QUESTIONS BEFORE HEALTH EXAMINATION

scr1 **Current health status – the table below lists several symptoms.**
For each symptom, please indicate whether you have experienced them in the last 2 weeks and whether you are currently experiencing them.

	Symptoms	Experienced in the last 2 weeks	Experienced in the last 24 hours
a	Cough	☐ No ☐ Yes →	☐ No ☐ Yes
b	Wheezing during breathing	☐ No ☐ Yes →	☐ No ☐ Yes
c	Respiratory distress	☐ No ☐ Yes →	☐ No ☐ Yes
d	Feeling of weakness	☐ No ☐ Yes →	☐ No ☐ Yes
e	Stuffy nose	☐ No ☐ Yes →	☐ No ☐ Yes
f	Flu / flu-like symptoms	☐ No ☐ Yes →	☐ No ☐ Yes
g	Fever	☐ No ☐ Yes →	☐ No ☐ Yes
h	Chest pain	☐ No ☐ Yes →	☐ No ☐ Yes → ***see 2.4-WI-HEA-09-Chest pain***

Notes/Comments :

scr2	Please answer the following questions about infections that have occurred in recent weeks	
a	In the last few weeks, have you had a respiratory tract infection? For how many days have you been completely cured of this infection?	☐ No **→ *please proceed to question scr3*** ☐ Yes, when did you contract it? Date: __-__-__ (D-M-Y) _____
b	Have you contracted any other infection? Which kind of infection was it? For how many days have you been completely cured of this infection?	☐ No **→ *please proceed to question scr3*** ☐ Yes, when did you contract it? Date: __-__-__ (D-M-Y) _____
c	Have you contracted any other infection? Which kind of infection was it? For how many days have you been completely cured of this infection?	☐ No **→ *please proceed to question scr3*** ☐ Yes, when did you contract it? Date: __-__-__ (D-M-Y) _____
d	Have you contracted any other infection? Which kind of infection was it? For how many days have you been completely cured of this infection?	☐ No **→ *please proceed to question scr3*** ☐ Yes, when did you contract it? Date: __-__-__ (D-M-Y) _____

scr3	Please answer the following questions:	
a	When was the last time you ate or drank a sweetened beverage?	___ :___ (H:M) (Format 24:00)
b	In the last 24 hours, did you engage in any strenuous physical activity?	☐ No ☐ Yes, when was this? ___ :___ (H:M) (Format 24:00)
c	What is your smoking behaviour?	☐ Non-smoker ***→ please proceed to subquestion -e*** ☐ Former smoker ***→ please proceed to subquestion -e*** ☐ Smoker
d	Have you smoked in the last hour?	☐ No ☐ Yes
e	At night, do you use a nasal dilator (nasal strip) to help you breathe more easily?	☐ No ☐ Yes
f	Do you do oxygen therapy?	☐ No ☐ Yes, when required ☐ Yes, at night ☐ Yes, during the day ☐ Yes, at night and during the day
g	Do you need continuous positive airway pressure (CPAP) at night (with nasal mask)?	☐ No ☐ Yes

scr4	Please answer the following questions about medication used to improve breathing	
a	In the last 12 months, have you used an inhalation product?	☐ No → *please proceed to subquestion –c* ☐ Yes
b	Which medication, what was the dosage and when have you inhaled it?	_____
c	In the last six hours, have you taken any breathing medication?	☐ No → *please proceed to subquestion -e* ☐ Yes, more than an hour ago ☐ Yes, less than an hour ago
d	Which medication, what was the dosage and when have you inhaled it?	_____
e	In the last 12 months, have you taken any inhaled medication to help you breathe more easily?	☐ No → *please proceed to subquestion -g* ☐ Yes ☐ I don't know
f	Please list any aerosols you have used in the last 12 months.	_____ _____ _____ _____ _____ _____ _____
g	In the last 12 months, have you taken any pills, capsules or tablets to help you breathe more easily?	☐ No → *please proceed to question scr5* ☐ Yes ☐ I don't know
h	Please list the name of all these pills, capsules or tablets you have used in the last 12 months.	_____ _____ _____ _____ _____ _____

scr5 **Please answer the following questions about antibiotics:**

Antibiotics can be administered by infusion, intramuscular injections, tablets or syrups. Please DO NOT COUNT antibiotic creams or any other external application.

a How often have you taken antibiotics in the last 12 months?

☐ No treatment in the last 12 months → ***please proceed to question scr6***
☐ One treatment in the last 12 months
☐ Two treatments in the last 12 months
☐ Three to four treatments in the last 12 months
☐ More than four treatments in the last 12 months
☐ I don't know

b When did you last take antibiotics? Which drug was it?

	Date (DD.MM.YYYY)	**(I don't know)**	**Drug name**	**(I don't know)**
Drug 1	_____	☐	_____	☐
Drug 2	_____	☐	_____	☐
Drug 3	_____	☐	_____	☐

scr6 **If you are a woman, please answer the following questions about menstruation:**

a **Are you still menstruating?**

☐No→ I haven't had my period since: Month (MM) _____ Year (YYYY) _____

☐Yes → When did you last have your period? Month (MM) _____ Year (YYYY) _____

b **If yes, are you currently menstruating?**

☐Yes → ***please proceed to question scr7***
☐No, and I am not pregnant → ***please proceed to question scr7***
☐No, I am pregnant → ***no BIA*** ***If on third trimester → no spirometry***
☐No, and I don't know if I'm pregnant → ***veuillez passer à la question scr7***

c Which trimester?

☐ First trimester
☐ Second trimester
☐ Third trimester → ***no spirometry***

scr7	**Exclusion criteria for BP - Please answer the following questions.**		
a	Have you undergone radiotherapy or had lymph node removed from your armpit(s), e.g. after breast cancer?	☐ No ☐ Yes, on the right side ☐ Yes, on the left side ☐ Yes, on both sides	 → BP** → BP** → No BP
b	Do you have a brachial artery shunt?	☐ No ☐ Yes, on the right side ☐ Yes, on the left side ☐ Yes, on both sides	 → BP** → BP** → No BP

**BP: Place the BP cuff on the other side and make a note of it.

scr8	**Exclusion criteria for BIA - Please answer the following questions.**			
a	Do you have vasoconstrictions in the legs or arms, which lead to blood circulation disorders?	☐ No	☐ Yes	
b	Have you ever undergone surgery of the carotid artery or aorta?	☐ No	☐ Yes	
c	Do you have metal joint prostheses?	☐ No	☐ Yes	→ no BIA
d	Have you had a leg amputation?	☐ No	☐ Yes	→ no BIA
e	Have you had an arm amputation?	☐ No	☐ Yes	→ no BIA
f	Do you have a pacemaker?	☐ No	☐ Yes	→ no BIA
g	Do you have an implanted defibrillator?	☐ No	☐ Yes	→ no BIA
h	Do you have extensive oedema, gangrene (tissue necrosis) or ulcers on your legs or arms?	☐ No	☐ Yes	→ no BIA
i	Do you have a cochlear implant?	☐ No	☐ Yes	→ no BIA

scr9	**Exclusion criteria for spirometry – Please answer the following questions**		
a	In the last 3 months, have you undergone surgery in the area of the chest or of your stomach?	☐ No ☐ Yes	→ ***no spirometry***
b	Do you suffer from retinal detachment or have you undergone eye surgery in the last 3 months?	☐ No ☐ Yes	→ ***no spirometry***
c	Have you had a pneumothorax (collapsed lung)?	☐ No ☐ Yes	→ ***no spirometry***
d	Have you had an aortic aneurysm?	☐ No ☐ Yes	→ ***no spirometry***
e	Have you had a pulmonary embolism in the last 3 months?	☐ No ☐ Yes	→ ***no spirometry***
f	Have you had a myocardial infarction in the last 3 months?	☐ No ☐ Yes	→ ***no spirometry***
g	Have you been hospitalized for heart problems in the last 4 weeks?	☐ No ☐ Yes	→ ***no spirometry***
h	Are you currently suffering from tuberculosis?	☐ No ☐ Yes	→ ***no spirometry***
i	Are you currently taking medication for tuberculosis?	☐ No ☐ Yes	→ ***no spirometry***
j	Are you currently suffering from pneumonia or any other lung disease requiring oxygen therapy?	☐ No ☐ Yes	→ ***no spirometry***
k	Have you had any head injury or undergone brain surgery in the last 3 months?	☐ No ☐ Yes	→ ***no spirometry***
l	Have you suffered a stroke in the last 3 months?	☐ No ☐ Yes	→ ***no spirometry***
m	Are you currently suffering from an otitis (middle ear infection)?	☐ No ☐ Yes	→ ***no spirometry***
n	Have you coughed up blood in the last month (in sputum)?	☐ No ☐ Yes	→ ***no spirometry***
o	Do you have a physical condition that prevents you from taking a deep breath?	☐ No ☐ Yes	→ ***no spirometry***
p	Are you currently pregnant or breastfeeding?	☐ No ☐ Yes	→ ***if third trimester of pregnancy, no spirometry***

scr12	**Exclusion criteria for hand grip strength examination - Please answer the following questions**		
a	Have you undergone any hand or wrist surgery in the last 3 months?	☐ No ☐ Yes	→ ***HG*****
b	Do you have any other injuries that could prevent you from undertaking a hand grip strength test? E.g. hand wounds, plaster cast, prostheses?	☐ No ☐ Yes	→ ***HG*****

HG**: perform HG examination on the other side.

scr13	Questions for the OPEA test (Lausanne) - Please answer the following questions	
scr13.1	**In the last 24 hours, have you consumed…:**	
a	Nuts (almonds, walnuts, hazelnuts...)	☐ No ☐ Yes
b	Fresh fruit or fresh fruit juice (sugar-free)	☐ No ☐ Yes
c	Fresh vegetables	☐ No ☐ Yes
d	Indian spices (turmeric, cumin...)	☐ No ☐ Yes
e	Raw vegetable oils	☐ No ☐ Yes
f	Processed products (industrial cookies, sweets, potato chips, chocolate, etc.)	☐ No ☐ Yes
g	Fried food (French fries, hamburgers, etc.)	☐ No ☐ Yes
h	Coffee or tea	☐ No ☐ Yes
i	Red wine	☐ No ☐ Yes
scr13.2	**Please indicate the time spent in each of the following means of transport to get here today:**	
a	Train	_____ (min)
b	Underground	_____ (min)
c	Bus	_____ (min)
d	Car	_____ (min)
e	Walking/scooter	_____ (min)
f	Bicycle (including electric bike)	_____ (min)
g	Tram	_____ (min)
h	Motorcycle/ Scooter (moped)	_____ (min)
i	Boat	_____ (min)
scr13.3	**Are you currently suffering from:**	
a	Asthma?	☐ No ☐ Yes
b	Allergic rhinitis?	☐ No ☐ Yes
c	Any other respiratory disease?	☐ No ☐ Yes

scr13.4	**In the last 24 hours, have you taken:**	
a	Any medication: If yes, Medication - please indicate which one(s):	☐ No → ***please proceed to subquestion -b*** ☐ Yes _____ _____ _____ _____ _____ _____
b	Any dietary or vitamin supplement: If yes, Dietary or vitamin supplement - please indicate which one(s):	☐ No → ***please proceed to subquestion -c*** ☐ Yes _____ _____ _____ _____
c	Any other treatment: If yes, Other treatment - please indicate which one(s):	☐ No → ***please proceed to question scr13.5*** ☐ Yes _____ _____ _____ _____
scr13.5	**Please indicate how much, in the last 24 hours, you have smoked of:** **(indicate '0' if you are a non-smoker)**	
	If non-smoker or former smoker: **The participant indicated that he/she is non-smoker/former smoker**	
	If smoker :	
a	Cigarettes	_____
b	Cigars	_____
c	Pipes	_____
d	Cigarillos	_____
e	E-cigarettes (if refillable, please indicate the nicotine dose)	_____
	Notes/Comments : _____ _____ _____ _____ _____	

Instrument: Blood pressure

2.a	Blood pressure

Depending on « PEF – Screening questionnaire » answers, appearance of the following text on REDCap:

Blood pressure: the participant is not eligible for this exam

☐ Examination not performed

Device used:	☐ SHeS-BP01L ☐ SHeS-BP02L ☐ SHeS-BP01-Bern
Cuff size?	☐ large ☐ standard

Measurements must be taken on the LEFT arm unless the participant has undergone radiotherapy or lymph node removal in the left armpit or has had a shunt in the brachial artery on the left side.
In this case, place the blood pressure cuff on the right side and indicate it in the comments' section.

Depending on « PEF – Screening questionnaire » answers, appearance of the following text on REDCap:

The participant has undergone radiotherapy or lymph node removal in one armpit or has had a brachial artery shunt on one side.

Place the BP cuff on the other side and note it.

Side:	☐ left ☐ right
Arm circumference:	_____cm

a.1 RESULTS

RESULTS	Measurement 1	Minimum 1min in-between*	Measurement 2	Minimum 1min in-between*	Measurement 3
Time according to blood pressure monitor: (Format: 24:00):	_ _ : _ _ time (H :M)		_ _ : _ _ time (H :M)		_ _ : _ _ time (H :M)
Systolic BP:	_____ mmHg		_____ mmHg		_____ mmHg
Diastolic BP:	_____ mmHg		_____ mmHg		_____ mmHg
Pulse :	_____ bpm		_____ bpm		_____ bpm

Important info FW: Wait at least 1 minute between measurements.

2.b	**Additional questions for the waiting time between the three measurements**
a	If you measure your blood pressure yourself at home, is the blood pressure measured here higher, lower or equivalent to that measured at home? ***FW info:*** *please take the lowest value of the three measurements as a comparison* ☐ I do not measure my blood pressure at home ***→ please proceed to sub-question -3 (PEF-HAND Grip)*** ☐ lower ☐ equivalent ☐ higher
b	When you measure your blood pressure at home at rest, are the values always more or less the same or do the values vary considerably from one measurement to the next? ☐ Yes, the values are more or less identical systolic_ _ _ / diastolic_ _ ☐ No, the values are very different from one measurement to another ***Lowest values*** ***Highest values*** systolic_ _ _ / diastolic_ _ systolic_ _ _ / diastolic_ _
Notes/Comments :	

Instrument: Hand grip (HG)

3	**Hand grip measurement test**

Depending on « PEF – Screening questionnaire » answers, appearance of the following text on REDCap:

The participant has undergone surgery on his/her hands or wrists or declares that he/she has suffered other injuries that prevent a grip strength test.
Perform hand grip test on the other side.

☐ Examination not performed

a	Start of test:	_ _ : _ _ (H :M) (Time format: 24:00)	
b	Device used:	☐ SHeS-HG01L ☐ SHeS-HG01-Bern ☐ SHeS-HG02-Bern	
c	Dominant hand?	☐ Right-handed	☐ Left-handed
d	Hand used to perform the test	☐ Right	☐ Left
e	Measurement 1	__ __ kg	
f	Measurement 2	__ __ kg	
g	Measurement 3	__ __ kg	

Notes/Comments _____
_____

If not yet done: Now offer to provide a urine sample

The bladder must be emptied at the latest before the BIA and preferably also before the anthropometric measurements. If the participant is unable to provide a sufficient quantity of urine for analysis before the BIA, he/she is entitled to drink as much water as he/she wishes after the BIA.

Notes/Comments :

_____
_____
_____
_____
_____

Instrument: Anthropometry

4	Height, weight, waist circumference, hip circumference and neck circumference			
				☐ Examination not performed
	Device used - weight:			☐ CRC-WE01 ☐ Bern-WE01
	Device used - height:			☐ CRC-HE01 ☐ Bern-HE01
	Measuring tape:			☐ SHES-TM01 ☐ SHES-TM02 ☐ SHES-TM01-Bern
	Neck circumference:	___._ cm (e.g. 27.8)	Height:	___._ cm (e.g. 178.5)
	Weight:	___. _ Kg (e.g. 80.4)	Waist circumference:	___._ cm (e.g. 50.2)
	Hip circumference:	___._ cm (e.g. 100.1)		
	BMI		_____	
	Notes/Comments :			

Instrument: BIA

5	Bioelectrical impedance analysis	
Depending on « PEF – Screening questionnaire » answers, appearance of the following text on REDCap: BIA: the participant is not eligible for this exam		
		☐ Examination not performed
a	Device used:	☐ SHES-BIA01 ☐ SHES-BIA02 ☐ SHES-BIA01-Bern
b	Room temperature:	_____ C°
	Notes/Comments :	

Instrument: Blood sample PoC

6	Finger pricks: HbA1c and lipid tests	
a	Nurse / FW ID	_____ (FW ID)
ALERE HbA1c Test		
Capillary blood sample 1		
b	Test performed:	☐ No ☐ Yes
b	Device used:	☐ SHES-AL01L ☐ SHES-AL02L ☐ SHES-AL01-Bern
b	Capillary blood sample 1:	☐ Right ☐ Left
b	Time of HbA1c Test:	_ _ : _ _ (H :M)
b	**RESULTS**	
	HbA1c	_____%
Problems with HbA1c Test Comments		_____
Capillary blood test 2		
c	Test performed:	☐ No ☐ Yes
c	Capillary blood test 2:	☐ Right ☐ Left
c	Time of Lipid Test:	_ _ : _ _ (H :M)
c	Device used:	☐ SHES-AL01L ☐ SHES-AL02L ☐ SHES-AL01-Bern
c	**RESULTS**	
	Total cholesterol	_____mmol/L
	LDL cholesterol	_____mmol/L
	HDL cholesterol	_____mmol/L
	Triglycerides	_____mmol/L
	Non-HDL cholesterol	_____mmol/L
	Cholesterol / HDL	_____
Problems with Lipid Test Comment		_____

Notes/Comments :

_____

_____

_____

Instrument: Spirometry

7	Spirometry	
Depending on « PEF – Screening questionnaire » answers, appearance of the following text on REDCap: Spirometry: the participant is not eligible for this exam.		
		☐ Examination not performed
	Device used:	☐ SHES-SP01L ☐ SHES-SP01-Bern
b	Start of examination:	_ _ : _ _ (H :M) (Time format: 24:00)
c	Room temperature:	____.__ °C (Take the info from your "weather station")
d	Humidity:	_____ % (Take the info from your "weather station")
e	Atmospheric pressure:	_____ hPa (Take the info from your "weather station")
Are spirometry results within the norm?		☐ Yes ☐ No

Notes/Comments :

_____

_____

_____

Instrument: OPEA

OPEA test	
	☐ Examination not performed
Start of test	__-__-__ __ :__ :__ (D-M-Y H :M :S)

Instrument: Qs completion

8	To finish, complete the questionnaires
	☐ Completed or already complete ☐ Not completed for the following reason (see comments)
Notes / Comments	_____ _____ _____ _____ _____

Instrument: Accelerometry

9	**Accelerometry**	
a	Was the accelerometer given to the participant?	☐ Yes ☐ No ☐ No accelerometer available
Create a Contact Activity - Accelerometer Registration		
b	Was the Contact Activity created on REDCap?	☐ Yes ☐ No
Notes/Comments :		

Instrument: MyFoodRepo

	MyFoodRepo app	
a	Has the participant agreed to use the MyFoodRepo app for 8 consecutive days?	☐ Yes → **Allocate identification key on MFR website** ☐ No ☐ The app was not offered to the participant (please indicate the reason in the comments)
If yes :		
b	Has the MFR identification key been allocated to the participant?	☐ Yes ☐ No
MFR identification key :		_____
Presumed date of start of use:		__-__-__
Presumed date of end of use:		__-__-__
Withdrawal of acceptance: after the visit, the participant in the end refused to use the app		☐ Withdrawn
Notes/Comments :		

Instrument: Communication

RESULTS' OVERVIEW		
10	**Eligibility for Selenium sub-study**	
Has the participant agreed to complete the Selenium sub-project questionnaire?		☐ Yes → **In PMT, under « participant's details », click on "Add participant to Selenium"** ☐ No ☐ The participant is not a Selenium participant ☐ Not applicable
11	**Overview of results and materials provided to the participant**	☐ Health examination results ☐ BIA report ☐ Spirometry report ☐ Accelerometer equipment ☐ MyFoodRepo guidelines ☐ Selenium Flyer reminder (Lausanne only) ☐ Participation certificate ☐ None
Please tick this box if the participant wishes to receive his/her laboratory results		☐ Laboratory results to be sent
12	**Incidental Findings Registration**	
Notes/Comments :		

Instrument: Venous Blood Collection

13	Blood collection	
		☐ Examination not performed
a	Start of blood draw:	_ _ : _ _ (H :M) (Time format: 24:00)
a	End of blood draw:	_ _ : _ _ (H :M) (Time format: 24:00)

Notes/Comments :

14	End of health examination	
End of health examination :		_ _ : _ _ (H :M) (Time format: 24:00)
FW identification:		_____ (@username)

For me. For all.
Swiss health study

Pilot phase

Your potential contribution (A2)

Interview during the study visit

1	**Do you think other members of your family or friends would be interested in taking part in a health study?**
	☐ Yes
	☐ No
	☐ I don't know

2	**Would you be willing to travel with your minor child, with his/her consent, to a study centre in your area for a brief health examination?**
	☐ Yes
	☐ No
	☐ I don't know

3	**Would you be willing to have your pet examined by a vet to help us better understand the links between human and animal health?**
	☐ Yes
	☐ No
	☐ I don't know

4	**How do you feel about the use of smartphone apps? Would you agree to record your physical activity or diet using an app on your smartphone?**
	☐ Yes
	☐ No
	☐ I don't know

5	**Would you be willing to use GPS tracking to record your location during one of your typical days?** *These data are useful for studying exposure to noise, air pollution or certain chemicals. The assessment does not take place in real time.*
	☐ Yes
	☐ No
	☐ I don't know

6	At what intervals would you be willing to complete additional questionnaires?
☐	Twice a year
☐	Annually
☐	Every 2 years
☐	Every 5 years
☐	I do not wish to answer any additional questionnaires

7	At what interval would you agree to be re-examined and donate biological material?
☐	Annually
☐	Every 2 years
☐	Every 5 years
☐	Every 10 years
☐	I do not wish to take part in any further examination

8	Would you be willing to have simple examinations (e.g. blood pressure and blood sugar measurements) carried out monthly at a pharmacy of your choice?
☐	Yes
☐	No
☐	I don’t know

9	Would you be willing to have further measurements taken using a measuring device at home (e.g. heart rate monitor)?
☐	Yes
☐	No
☐	I don’t know

10	Would you consider taking part in a large-scale Swiss health study (>100,000 participants)?
☐	Yes
☐	No
☐	I don’t know

11	**If you have any further information for us, please use the space below to provide any suggestions, requests, comments or criticism.**